Journ Child Adol Trauma (2018) 11:121–127
DOI 10.1007/s40653-017-0172-x

ORIGINAL ARTICLE

Exposure to Bullying Among Adolescents Across Nine Countries

Yoke Yong Chen[1,2] · **Ask Elklit**[3]

Published online: 13 July 2017

Abstract Bullying is not included in Diagnostic and Statistical Manual for Mental Disorders (DSM) criteria (Criteria A, APA, 2013) for posttraumatic stress disorder (PTSD), however, several studies have demonstrated the association between bullying (including those being the bully, victim) and PTSD. The aim of the present study was to investigate the relationship between bullying and PTSD and suicide attempts among adolescents across nine countries. A total of 4051 adolescents with a mean age of 14.9 years found that 36.6% of the adolescents reported exposure to bullying. There were some gender differences across countries. Bullying was significantly associated with PTSD symptoms and suicide attempts among the adolescents. National prevention plans and interventions are needed to prevent bullying.

Keywords Bullying · Adolescents · PTSD · Suicide attempt

Bullying behaviour among students is increasing across nations (Olweus and Limber 2010) and is considered as a leading adolescent health concern (Craig et al. 2009; Due et al. 2005; Nansel et al. 2003). This behaviour is considered to be a major public health problem rather than a temporal-related problem due to its high prevalence (Isolan et al. 2013; Ttofi et al. 2011). Previously, bullying was often undereported and ignored as it was considered to be a normal developmental process, especially for males at school (Kevorkian and D'Antona 2008). Various definitions of bullying have been published throughout the literature; however the most commonly used definition was defined by Olweus as when an individual "is exposed, repeatedly and over time, to negative actions on the part of one or more other students" (Olweus 1993, p 9). Bullying can involve physical and verbal abuse and social manipulation, for example: spreading rumours and making the individual feel uncomfortable, insecure and isolated from others over a prolonged period of time (Salleh and Zainal 2014).

Adolescence is a difficult developmental period due to biological changes (i.e. bodily change and puberty) interacting with social and psychological challenges such as identity issues, cognitive development, and social competence (Erikson 1959; Muuss 1975; Piaget 1972). According to the diathesis-stress model, this renders some young people more vulnerable to bullying (Swearer and Hymel 2015). Adolescents may participate in bullying others to gain peer acceptance and status in the group (Jessor 1991). A complex interaction between individual, family, peer and environment are argued to influence the involvement of adolescents in bullying behaviours, rather than individual characteristics alone (Swearer and Hymel 2015). A safe school environment and supportive parenting have been identified as important protective factors to redcue involvement in bullying activities (Olweus 1993; Olweus and Limber 2010; Swearer and Hymel 2015).

Evidence of the long term consequences of bullying on development and adjustment in later life have been well documented (Dempsey and Storch 2008; Ttofi et al. 2011; Van Geel et al. 2014). Victims and bullies are both more likely to

This article has not been published elsewhere and has not also been submitted simultaneously for publication elsewhere.

✉ Yoke Yong Chen
yongcyy@gmail.com

[1] Faculty of Medicine and Health Sciences, Universiti Malaysia Sarawak, Kota Samarahan, Sarawak, Malaysia

[2] Department of Psychological Medicine, Faculty of Medicine and Health Sciences, University Malaysia Sarawak, 94300 Kota Samarahan, Sarawak, Malaysia

[3] Department of Psychology, National Centre for Psychotraumatology, University of Southern Denmark, Odense, Denmark

develop mental health problems, such as suicidal ideation (Van Geel et al. 2014), depression (Uba et al. 2010), anxiety (Isolan et al. 2013), psychosocial problems (Ledley et al. 2006) low self-esteem, problems in interpersonal relationships (Dempsey and Storch 2008), and criminal offending (Ttofi et al. 2011) that persist to later adulthood (Copeland et al. 2013; Sourander et al. 2000).

A retrospective study in Norway reported that 46% of patients in a psychiatric clinic experienced bullying during childhood (Fosse and Holen 2004). Further, bullying during the age of 14–15 years was associated with reduced general functioning, leisure activities, and increased risk of psychiatric hospitalization by the age of 27 (Sigurdson et al. 2015). Carlisle and Rofes (2007) have even suggested that the effect of school bullying among children and adolescents was similar to those who have experienced child abuse.

In large samples of adolescents, studies have demonstrated that those involved in bullying (either bullies, victims, or bully-victims) exhibited a high level of anxiety symptoms (Copeland et al. 2013; Isolan et al. 2013; Sourander et al. 2000). Carney (2008) found that exposure to bullying impacts on an individuals' traumatic response to stress. Studies have also reported an association between bullying and PTSD symptoms (Hyman et al. 2003; Mynard et al. 2000; Idsoe et al. 2012). These traumatic symptoms can manifest through recurring intrusive thoughts about the experience, avoidance of peer interactions and feelings of powerlessness and helplessness (Crosby et al. 2010; Mynard et al. 2000). There is a paucity of studies examining the association between bullying and PTSD, however, some findings have indicated that more than a third of the English and Norwegian participants who experienced bullying suffered from PTSD symptoms (Mynard et al. 2000; Idsoe et al. 2012). Repeated bullying was also found to increase the risk for the development of PTSD symptoms among adolescents from Bosnia-Herzegovina as compared with those not having any bully or being bully experience (Obrdajj et al. 2013).

Exposure to bullying, especially during childhood and adolescence, might lead to the development of maladaptive beliefs regarding self, justice, and authorities (Moser et al. 2007). Newman et al. (2011) proposed that bullying at school might form a vicious cycle in coping stress that in turn lead to more stress among victims. Concern has grown over the increasing number of suicidal behaviour exhibited by adolescents who have exposure to high level of stress (Nock et al. 2013). Studies have further indicated an association between bullying and suicide attempts (Alavi et al. 2015; Luukkonen et al. 2009). For example, adolescents with a history of being bullied had a twofold increase in risk of suicidal ideation or suicide planning than those who have no bullying exposure (Alavi et al. 2015).

The aims of this study were to investigate the prevalence of bullying in a large sample of adolescents across nine countries along with the differences of gender distribution. The present study also aimed to investigate whether bullying was an independent predictor of PTSD and the association with suicide attempts among adolescents.

Method

Study Sample and Procedure

The data were collected from nine national representative probability samples from India, Uganda, Kenya, Lithuania, Denmark, the Faroe Islands, Greenland, Iceland, and Malaysia with a total numbers of 4051 adolescents (M_{age} = 14.9, SD = 1.69). Of the sample, 47.7% of participants were males, 46.9% were females and 5.5% were unstated (they were excluded in following data analysis which related to gender differences). Most of the participants were from Malaysia (25.1%), followed by The Faroe Islands (17%), Kenya (11.9%), India and Uganda (both 10.1%), Denmark (9.6%), Greenland (6.6%), Iceland (5.1%) and Lithuania (4.5%). Participants from India, Uganda, Kenya and Greenland were convenience samples which made up of 38.7% of the total participants. Information from the Faroese Ministry of Education, overall there were 804 students enrolled in eighth grade, and 85% of all the students agreed to participate in the study (n = 687). Participants from other countries were randomly selected (61.3%). Following ethical approval from institutional review boards in the various countries, schools were randomly selected from a list of all schools in the country. Most of the students were recruited from the school revealing a good representative of the adolescent sample in various countries. Parents and adolescents' written consent was a prerequisite for participating with the help from the schools. During data collection, participants were briefed on issues related to confidentiality and questionnaire collection procedures. For the detailed of procedure of data collection, please refer to the original studies (Bödvarsdóttir and Elklit 2007; Domanskaité-Gota et al. 2009; Elklit 2002; Petersen et al. 2010).

Measures

Demographic Questionnaire A one-page survey design was used to solicit information regarding participant age, gender, ethnicity, parental education, and living arrangements.

Traumatic Events Checklist This questionnaire contained a list of twenty traumatic and negative life events in the first column with direct exposure and indirect exposure (i.e. witnessing or experiencing an event themselves or having a person close to them experience an event) in the second columns. The list of traumatic events was selected from the

literature and clinical experience, including transportation accident, other serious accident, physical assault, abuse, rape, coming close to being injured or killed, near-drowning, attempted suicide, robbery, severe childhood neglect, humiliation or persecution by others, and other trauma. The validity of this checklist is supported by previous research (Elklit 2002).

Harvard Trauma Questionnaire (HTQ) Symptoms of PTSD were measured by HTQ (Mollica et al. 1992), a cross-cultural instrument to measure traumatic symptoms associated with diagnostic criteria for PTSD. It consists of 16 items on a 4-point Likert scale (1 = *not at all*, 4 = *extremely*) corresponding to the three major symptoms cluster of PTSD in DSM IV, avoidance (7 items), re-experiencing (4 items), and hypervigilance (5 items). Participants who rated 3 or 4 for at least one symptom in re-experiencing, two symptoms in hyper vigilance and three symptoms in avoidance, would be considered to have PTSD symptoms. The internal consistency of this questionnaire in the present study was high ($\alpha = .94$).

Results

The prevalence of bullying (including those being the bully, victim) was 36.6% across nine differents nations. The prevalence of bullying was the highest in Uganda (69.9%), followed by Kenya (51.6%), The Faroe Islands (49.9%), Denmark (34.6%), Iceland (33.5%), Malaysia (23.1%), India (21.7%), Greenland (20.1%) and Lithuania (14.2%).

The prevalence of bullying reported by males ranged from 8.4% (Lithuania) to 71.4% (Uganda). The prevalence of bullying reported by the females ranged from 15.1% (India) to 68.3% (Uganda) were (for detail please refer to Table 1). There were gender differences in terms of reporting bullying in general, $X^2 = 6.78$, $p = .009$, with males (38.8%) more likely to be engaged in bullying than females (34.9%; $X^2 = 6.78, p = .009$). There were significant gender differences in exposure to bullying in all countries except Uganda, Denmark and Iceland (Table 1). According to the report, as a whole more males (25.7%) had been directly involved in bullying when compared with the females (21%) and this has reached its significance level, $\chi^2 = 12.51, p < .001$. There were no significant gender differences in terms of indirect bullying exposure. India and Malaysia were the only two countries that found males have direct bullying exposure more than females, whereas Lithuania, The Faroe Islands and Greenland found more females than males involved in indirect bullying exposure (Table 2). This showed that males have higher possibilities involved in direct bullying in India and Malaysia, whereas females exposed more in indirect bullying at Lithuania, the Faroe Islands and the Greenland.

Table 1 The gender differences in reporting bullying in each countries ($N = 4051$)

	Female	Male	X^2	OR	95% C.I.for EXP(B)	
					Upper	Lower
India	15.1	27.4	9.11**	0.47	0.29	0.77
Uganda	68.3	71.4	0.48	0.86	0.5	1.32
Kenya	46.6	55.1	3.09*	0.71	0.49	1.04
Lithuania	19.2	8.4	4.27*	2.58	1.03	6.48
Denmark	38.5	30.8	2.58	1.41	0.93	2.15
The Faroe	54.4	46.2	4.45*	1.39	1.02	1.89
Greenland	23.8	14.9	3.24*	1.79	0.95	3.38
Iceland	36	31.1	0.55	1.25	0.70	2.24
Malaysia	20.1	28.3	9.07**	0.64	0.47	0.86

* $p < .05$, ** $p < .005$

Most of the traumatic events predicted PTSD among adolescents in a logistic regression analysis, ($\chi^2 = 444.00$, $p < .001$). This model explained 18.6% of the variance with 81.1% of the overall accuracy. Bullying was shown to be the strongest the predictor of PTSD among the various traumatic types (Table 3). However, bullying was significant predictor of PTSD only for youth in Uganda, Denmark, Greenland, and Iceland.

There was a significant relationship between bullying and suicide attempts, ($\chi^2 = 171.93$, $p < .001$). More than a half of the adolescents (67.7%) who attempted suicide were bullied while only 17.2% of the adolescents who were not exposed to bullying had attempted suicide. Those who had been bullied were 4.15 times more likely to have attempted suicide than those without bullied. There was a significant association between bullying and suicide attempts in the samples from Uganda, Kenya, the Faroe Islands, Greenland, Iceland, and Malaysia. Females (22.3%) with direct bullying exposure

Table 2 The gender differences in reporting direct and indirect exposure to bullying in each countries ($N = 4051$)

	Direct exposure			Indirect exposure		
	Female	Male	X^2	Female	Male	X^2
India	7.8	15.1	5.22*	9.4	13.7	1.85
Uganda	49.8	56.2	1.68	46.8	46.3	0.01
Kenya	28	34.7	2.22	29.8	36.7	2.25
Lithuania	13.1	6.0	2.56	14.1	3.6	5.91*
Denmark	26.6	18.5	3.64	21.4	17.4	0.95
The Faroe	30	30.9	0.07	39.9	30.3	6.81*
Greenland	7.9	9.6	0.24	17.2	7.0	6.04*
Iceland	23	23.3	0.003	18	12.6	1.13
Malaysia	11.3	17.2	7.12*	11.8	14.8	1.98

* $p < .05$

Table 3 The odd ratio of each traumatic events in predicting PTSD symptoms among adolescents ($N = 4051$)

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for Exp(B)	
							Lower	Upper
Road accident	−.28	.108	6.82	1	.01	.75	.61	.93
Other serious accident	.09	.114	.57	1	.45	1.09	.87	1.36
Violent attack	.15	.118	1.71	1	.19	1.17	.93	1.47
Rape	−.40	.149	7.09	1	.01	.67	.50	.90
Watched other people been injured or killed	.27	.120	5.10	1	.02	1.31	1.04	1.66
Being close to be injured or killed	.10	.123	.64	1	.42	1.10	.87	1.40
Being threatened by beating	.19	.116	2.62	1	.11	1.21	.96	1.52
Almost drowning	−.10	.107	.89	1	.35	.90	.73	1.11
Suicide attempt	.53	.117	20.48	1	.00	1.70	1.35	2.14
Robbery	.08	.116	.45	1	.50	1.08	.86	1.35
Pregnancy	−.52	.131	15.71	1	.00	.59	.46	.77
Serious illness	.37	.115	10.54	1	.00	1.45	1.16	1.82
Losing of family member	.24	.119	3.93	1	.05	1.27	1.00	1.60
Divorce	−.07	.111	.35	1	.55	.94	.75	1.16
Sexual abuse	.01	.151	.00	1	.96	1.01	.75	1.35
Physical abuse	.27	.132	4.33	1	.04	1.32	1.02	1.70
Neglect	.55	.131	17.19	1	.00	1.72	1.33	2.23
Bullying	**.55**	**.111**	**24.65**	**1**	**.00**	**1.74**	**1.40**	**2.16**
Absence of a parent	.31	.116	7.27	1	.01	1.37	1.09	1.72
Others	.06	.146	.17	1	.68	1.06	.80	1.41
Females	.54	.096	31.03	1	.00	1.71	1.42	2.07
Constant	−2.82	.126	501.98	1	.00	.06		

Note. Bold entries signifies that Bullying has the highest odd ratio in predicting PTSD symptoms among adolescents across nine countries

were 1.28 times more likely to attempt suicide than males (18.3%), although this difference was non-significant.

Discussion

The present study showed that the prevalence of bullying across nine countries was high (36.6%), with substantial variation across countries. For example, adolescents in Uganda reported rates five times higher than adolescents from Lithuania. The current findings nevertheless indicate that bullying likely occurs in all countries independently of geographic and cultural boundaries. The present estimates of bullying across nine countries were higher than a pooled estimate of 26% reported in a study that included 40 countries (Craig et al. 2009) and a Brazilian sample (22.9%; Isolan et al. 2013). However, the findings are consistent with estimates reported in England (Mynard et al. 2000) and Norway (Idsoe et al. 2012).

The higher rates of of bullying found in the Ugandan and Kenyan samples are in line with those of other African countries such as Zambia (60.9%; Fleming and Jacobsen 2009). A possible explanation for these findings in the African countries may reflect cultural differences in perceptions of bullying behaviours (Smith et al. 2002). According to Mandrup and Elklit (2014) and Morrell (2006), corporal punishment in African schools and families are still widely used practices asparents and teachers perceive corporal punishment to be a common child rearing practice.

Given the significant psychological, social and developmental consequences of bullying on adolescents (Van Geel et al. 2014; Isolan et al. 2013; Ttofi et al. 2011), these findings indicate the need for more awareness and anti-bullying campaigns in schools. For example, Olweus and colleagues developed the Olweus Bullying Prevention Programme (OBPP: Olweus 1993). This intervention is aimed at reducing bullying problems at school and emphasises the role of adults as positive role models in providing a consistent and non-hostile response to bullying in the school, classroom and at an individual level. The goals of this programme are to restructure the school environment by setting firm limits to unacceptable behaviours and promoting a sense of community for children and adults alike. The results of this intervention have been promising in Norway, where it was found that there was a relative 40% reduction in bullying after 1 year of the intervention (Olweus and Limber 2010).

The current findings also indicated that more male adolescents reported involvement in all kinds of direct bullying whereas more females were more involved in indirect bullying, which is in line with with previous studies (Craig et al. 2009; Isolan et al. 2013). Some studies document a stereotypic pattern of bullying in terms of gender differences with males more likely involved in direct bullying whereas females are more likely to be involved in relational aggression (Bjorkqvist 1994). Moreover, in relation to PTSD, females had a higher levels of PTSD symptoms related to bullying than boys which supports the findings of a nationally representative study of children in Norway (Idsoe et al. 2012). This suggests that although males were more involved in bullying, the effects were more severe for females. The effects of a traumatic event on the individual largely depends on one's appraisal of the event rather than the event itself (Folkman and Lazarus 1988). The female adolescents in the present study might perceived their bullying experiences more seriously and therefore developeded a higher level of PTSD symptoms.

The association between bullying and PTSD in the present study further supports previous findings (Idsoe et al. 2012; Mynard et al. 2000). Studies have identified higher levels of PTSD symptoms were reported by individuals who experienced interpersonal traumatic experiences compared to non-interpersonal trauma like car accidents (Lancaster et al. 2009). A possible explanation for these findings is that bullying has been associated with negative emotional valence, for example, feelings of helplessness and loneliness (Due et al. 2005). Indeed these emotions were demonstrated to significantly predict PTSD symptoms among African-American and European-Ameriacan participants (Lancaster et al. 2011).

Finally, the current findings also found a higher rate of suicide attempt in adolescents who were bullied compared to those who were not bullied. This supports previous studies that have reported associations between bullying and suicidal behaviours (Alavi et al. 2015; Hay and Meldrum 2010; Randall et al. 2014). Further, in a retrospective study conducted in the United Kingdom, Meltzer et al. (2011) examined the association between bullying victimization during childhood and suicide attempts over the life course and found adults who were bullied during childhood were more than twice as likely as non-bullied adults to attempt suicide later in life.

This study is not without limitation. Firstly, bullying and attempted suicide were measured through the use of single item questions drawn from a larger measure of childhood traumatic experiences; therefore the results should be interpreted cautiously. Information regarding students whether resided in school dormitory or non-resident school dormitory was not included in the present study. Studies have showed that students who resided in school dormitories were more likely to be exposed to bullying incidents than those non-resident students (Chui and Chan 2015; Pfeiffer and Pinquart 2014). The cross-sectional design restricts conclusions about causality and how these findings may change over time.

Furthermore, the current study did not examine bully-victims. Copeland et al. (2013) showed that bully-victims (i.e. individuals who are involved in bullying others and have been victimized by bullying) exhibited the higher levels of anxiety when compared with either being a bully or victim. Similarly, in order to address bullying problems at school, the issue of bystanders should be considered as suggested by Hazler (1996), Salmivalli (2010) and Salmivalli et al. (2010). Bystanders were shown to be the encouraging factor of bullying (Trach et al. 2010). Therefore, future studies examining different profiles of bullying involvement, (i.e. bullies, victims, bully-victims and bystanders) would give a more comprehensive picture of the bullying incidents in relation to PTSD among adolescents.

In conclusion, the occurrence of bullying at school transcends geographical and cultural boundaries and calls attention to diminish and prevent bullying among adolescents. The present study provided valuable information about the suicidal attempts among adolescents who have been exposed to bullying. The results calls for the need for future research to increase understanding of complex relationship between the bullying, suicide attempts and PTSD among the adolescents. Prevention of bullying at school should be implemented at the national level.

Acknowledgments Sincere thanks to all participants who gave us their full cooperation during the data collection. Authors wish to thank Siobhan Murphy for assistance with editing.

Compliance with Ethical Standards

Funding This study was funded by the National Centre for Psychotraumatology University of Southern Denmark: Grant No UNIMAS L18403 F05 00 PTSD.

Conflict of Interest All authors declare that they have no conflicts of interest to report.

Ethical Standards and Informed Consent All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation [institutional and national] and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for being included in the study.

References

Alavi, N., Nasreen Roberts, M., Axas, N., & Repetti, L. (2015). Bullying victimization (being bullied) among adolescents referred for urgent psychiatric consultation: prevalence and association with suicidality. *Canadian Journal of Psychiatry, 60*, 427–431.

Bjorkqvist, K. (1994). Sex differenecs in physical, verbal, and indirect aggression: a review of recent research. *Sex Roles, 30*, 177–188.

Bödvarsdóttir, Í., & Elklit, A. (2007). Victimization and PTSD-like states in an Icelandic youth probability sample. *BMC Psychiatry, 7*, 51–57.

Carlisle, N., & Rofes, E. (2007). School bullying: do adult survivors perceive long-term effects? *Traumatology, 13*, 16–26.

Carney, J. (2008). Perceptions of bullying and associated trauma during adolescence. *Professional School Counseling, 11*, 179–188.

Chui, W. H., & Chan, H. C. O. (2015). Self-control, school bullying perpetration, and victimization among Macanese adolescents. *Journal of Child and Family Studies, 24*, 1751–1761.

Copeland, W. E., Wolke, D., Angold, A., & Costello, E. J. (2013). Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence. *JAMA Psychiatry, 70*, 419–426.

Craig, W., Harel-Fisch, Y., Fogel-Grinvald, H., Dostaler, S., Hetland, J., Simons-Morton, B., et al. (2009). A cross-national profile of bullying and victimization among adolescents in 40 countries. *International Journal of Public Health, 54*, 216–224.

Crosby, J. W., Oehler, J., & Capaccioli, K. (2010). The relationship between peer victimization and post-traumatic stress symptomatology in a rural sample. *Psychology in the Schools, 47*, 297–310.

Dempsey, A. G., & Storch, E. A. (2008). Relational victimization: the association between recalled adolescent social experiences and emotional adjustment in early adulthood. *Psychology in the Schools, 45*, 310–322.

Domanskaité-Gota, V., Elklit, A., & Christiansen, D. M. (2009). Victimization and PTSD in a Lithuanian national youth probability sample. *Nordic Psychology, 61*(3), 66–81.

Due, P., Holstein, B. E., Lynch, J., Diderichsen, F., Gabhain, S. N., Scheidt, P., & Currie, C. (2005). Bullying and symptoms among school-aged children:international comparative cross sectional study in 28 countries. *The European Journal of Public Health, 15*, 128–132.

Elklit, A. (2002). Victimization and PTSD in a Danish national youth probability sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 174–181.

Erikson, E. H. (1959). Identity and the life cycle: Selected papers. *Psychological issues,* 1(1). New York: International Universities Press.

Fleming, L. C., & Jacobsen, K. H. (2009). Bullying among middle-school students in low and middle income countries. *Health Promotion International, 25*, 73–84.

Folkman, S., & Lazarus, R. (1988). The relationship between coping and emotions: implications for theory and research. *Social Science & Medicine, 26*, 309–317.

Fosse, G. K., & Holen, A. (2004). Cohabitation, education, and occupation of psychiatric outpatients bullied as children. *The Journal of Nervous and Mental Disease, 192*, 385–388.

Hay, C., & Meldrum, R. (2010). Bullying victimization and adolescent self-harm: testing hypotheses from general strain theory. *Journal of Youth and Adolescence, 39*, 446–459.

Hazler, R. J. (1996). Bystanders: an overlooked factor in peer on peer abuse. *Journal for the Professional Counselor, 11*, 11–21.

Hyman, I., Cohen, I., & Mahon, M. (2003). Student Alienation Syndrome: A paradigm for understanding the relation between school trauma and school violence. *The California School Psychologist, 8*, 73–86.

Idsoe, T., Dyregrov, A., & Idsoe, E. C. (2012). Bullying and PTSD symptoms. *Journal of Abnormal Child Psychology, 40*, 901–911.

Isolan, L., Salum, G. A., Osowski, A. T., Zottis, G. H., & Manfro, G. G. (2013). Victims and bully-victims but not bullies are groups associated with anxiety symptomatology among Brazilian children and adolescents. *European Child & Adolescent Psychiatry, 22*, 641–648.

Jessor, R. (1991). Risk behavior in adolescence: a psychosocial framework for understanding and action. *Journal of Adolescent Health, 12*(8), 597–605.

Kevorkian, M., & D'Antona, R. (2008). *101 facts about bullying: What everyone should know.* Lanham: R&L Education.

Lancaster, S. L., Melka, S. E., & Rodriguez, B. F. (2009). An examination of the differential effects of the experience of DSM-IV defined traumatic events and life stressors. *Journal of Anxiety Disorders, 23*, 711–717.

Lancaster, S. L., Melka, S. E., & Rodriguez, B. F. (2011). Emotional predictors of PTSD symptoms. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*, 313–317.

Ledley, D. R., Storch, E. A., Coles, M. E., Heimberg, R. G., Moser, J., & Bravata, E. A. (2006). The relationship between childhood teasing and later interpersonal functioning. *Journal of Psychopathology and Behavioral Assessment, 28*, 33–40.

Luukkonen, A. H., Räsänen, P., Hakko, H., & Riala, K. (2009). Bullying behavior is related to suicide attempts but not to self-mutilation among psychiatric inpatient adolescents. *Psychopathology, 4*, 131–138.

Mandrup, L., & Elklit, A. (2014). Victimization and PTSD in Ugandan youth. *Open Journal of Epidemiology, 4*, 141–156.

Meltzer, H., Vostanis, P., Ford, T., Bebbington, P., & Dennis, M. S. (2011). Victims of bullying in childhood and suicide attempts in adulthood. *European Psychiatry, 26*, 498–503.

Mollica, R. F., Caspi-Yavin, Y., Bollini, P., Truong, T., Tor, S., & Lavelle, J. (1992). The Harvard trauma questionnaire: validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. *Journal of Nervous and Mental Disease, 180*, 111–116.

Morrell, R. (2006). Corporal punishment in South African schools: a neglected explanation for its existence. *South African Journal of Education, 21*, 292–299.

Moser, J. S., Hajcak, G., Simons, R. F., & Foa, E. B. (2007). Posttraumatic stress disorder symptoms in trauma-exposed college students: The role of trauma-related cognitions, gender, and negative affect. *Journal of Anxiety Disorders, 21*, 1039–1049.

Muuss, R. E. (1975). *Theories of adolescence* (3rd ed.). New York: Random House.

Mynard, H., Joseph, S., & Alexander, J. (2000). Peer victimization and posttraumatic stress in adolescents. *Personality and Individual Differences, 29*, 815–821.

Nansel, T. R., Overpeck, M. D., Haynie, D. L., Ruan, W. J., & Scheidt, P. C. (2003). Relationships between bullying and violence among US youth. *Archives of Pediatrics & Adolescent Medicine, 157*, 348–353.

Newman, M. L., Holden, G. W., & Delville, Y. (2011). Coping with the stress of being bullied: consequences of coping strategies among college students. *Social Psychological and Personality Science, 2*, 205–211.

Nock, M. K., Green, J. G., Hwang, I., McLaughlin, K. A., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2013). Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: results from the National Comorbidity Survey Replication Adolescent Supplement. *JAMA Psychiatry, 70*, 300–310.

Obrdajj, E. C., Sesar, K., Santic, Z., Klaric, M., Sesar, I., & Rumboldt, M. (2013). Trauma symptoms in pupils involved in school bullying — a cross-sectional study conducted in Mostar, Bosnia and Herzegovina. *Collegium Antropologicum, 37*, 11–16.

Olweus, D. (1993). *Bullying in schools. What we know and what we can do*. Oxford: Blackwell.

Olweus, D., & Limber, S. P. (2010). Bullying in school: evaluation and dissemination of the Olweus Bullying Prevention Program. *American Journal of Orthopsychiatry, 80*, 124–134.

Petersen, T., Elklit, A., & Olesen, J. G. (2010). Victimization and PTSD in The Faroese youth total-population sample. *Scandinavian Journal of Psychology, 51*, 56–62.

Pfeiffer, J. P., & Pinquart, M. (2014). Bullying in German boarding schools: a pilot study. *School Psychology International, 35*, 580–591.

Piaget, J. (1972). Intellectual evolution from adolescence to adulthood. *Human Development, 15*, 1–12.

Randall, J. R., Doku, D., Wilson, M. L., & Peltzer, K. (2014). Suicidal behaviour and related risk factors among school-aged youth in the Republic of Benin. *PloS One, 9*, e88233.

Salleh, N. M., & Zainal, K. (2014). Bullying among secondary school students in Malaysia: A case study. *International Education Studies, 7*(13), 184–191.

Salmivalli, C. (2010). Bullying and the peer group: a review. *Aggression and Violent Behavior, 15*, 112–120.

Salmivalli, C., Kärnä, A., & Poskiparta, E. (2010). From peer putdowns to peer support: a theoretical model and how it translated into a national anti-bullying program. In S. Jimerson, S. Swearer, & D. Espelage (Eds.), *Handbook of bullying in schools: an international perspective* (pp. 441–454). New York: Routledge.

Sigurdson, J. F., Undheim, A. M., Wallander, J. L., Lydersen, S., & Sund, A. M. (2015). The long-term effects of being bullied or a bully in adolescence on externalizing and internalizing mental health problems in adulthood. *Child and Adolescent Psychiatry and Mental Health, 9*, 1–13.

Smith, P. K., Cowie, H., Olafsson, R. F., & Liefooghe, A. P. (2002). Definitions of bullying: a comparison of terms used, and age and gender differences, in a fourteen–country international comparison. *Child Development, 73*, 1119–1133.

Sourander, A., Helstelä, L., Helenius, H., & Piha, J. (2000). Persistence of bullying from childhood to adolescence—a longitudinal 8-year follow-up study. *Child Abuse & Neglect, 24*, 873–881.

Swearer, S. M., & Hymel, S. (2015). Understanding the psychology of bullying: moving toward a social-ecological diathesis–stress model. *American Psychologist, 70*, 344–353.

Trach, J., Hymel, S., Waterhouse, T., & Neale, K. (2010). Bystander responses to school bullying: a cross-sectional investigation of grade and sex differences. *Canadian Journal of School Psychology, 25*, 114–130.

Ttofi, M. M., Farrington, D. P., Losel, F., & Loeber, R. (2011). Do the victims of school bullies tend to become depressed later in life? A systematic review and meta-analysis of longitudinal studies. *Journal of Aggression, Conflict and Peace Research, 3*, 63–73.

Uba, I., Yaacob, S. N., & Juhari, R. (2010). Bullying and its' relationship with Depression among Teenagers. *The Journal of Psychology, 1*, 15–22.

Van Geel, M., Vedder, P., & Tanilon, J. (2014). Relationship between peer victimization, cyberbullying, and suicide in children and adolescents: a meta-analysis. *JAMA Pediatrics, 168*, 435–442.